Improving Quality and Performance Private Midwifery Clinics; Lessons Learned from a Partnership with the Indonesian Midwives Association

Anne Pfitzer
Astrid Sulistomo
Damar Suryaningsih

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For more information on this report/publication, please contact Indonesia USAID office or direct inquiries to the address below.

STARH Program
Tifa Building 5/F
Jl. Kuningan Barat 26,
Jakarta 12710, Indonesia
Phone: (62-21) 525 2174; Fax (62-21) 522 9271
E-mail: starh@jhuccp.or.id

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Introduction

This report documents a small project implemented by the STARH Program with 5 private IBI clinics. These clinics offer a range of services including family planning, essential maternal and neonatal care as well as primary health care to children and adults, such as immunizations and basic curative services. The Indonesian Midwives Association (*Ikatan Bidan Indonesia* or IBI) established a foundation, Yayasan Buah Delima, in order to generate income for IBI. The IBI clinics are created by IBI board members (*pengurus*) and managed by foundation staff. A portion of clinic revenues reverts to the Foundation and are used to support IBI membership activities. The SDES project and IBI members themselves reported that the clinics were not operating at the desired level of quality and caseload for either family planning or maternal and child health services. In order to improve the performance of the IBI clinics, as well as the supervisory skills of clinic managers and supervisors, a project was developed in April 2001 with IBI national board members in Jakarta, to apply the performance improvement process in a sample of IBI clinics. Five clinics were selected based on 1) their location in a STARH province and 2) their potential to successfully implement the PI process. The clinics were:

- Klinik Buah Delima PDIBI, Bandung, West Java
- Klinik Model IBI, Deli Serdang, North Sumatra
- Klinik Bersalin IBI, Bandar Lampung, Lampung
- Klinik IBI, DKI Jakarta
- Klinik Model IBI "Kutisari", Surabaya, East Java

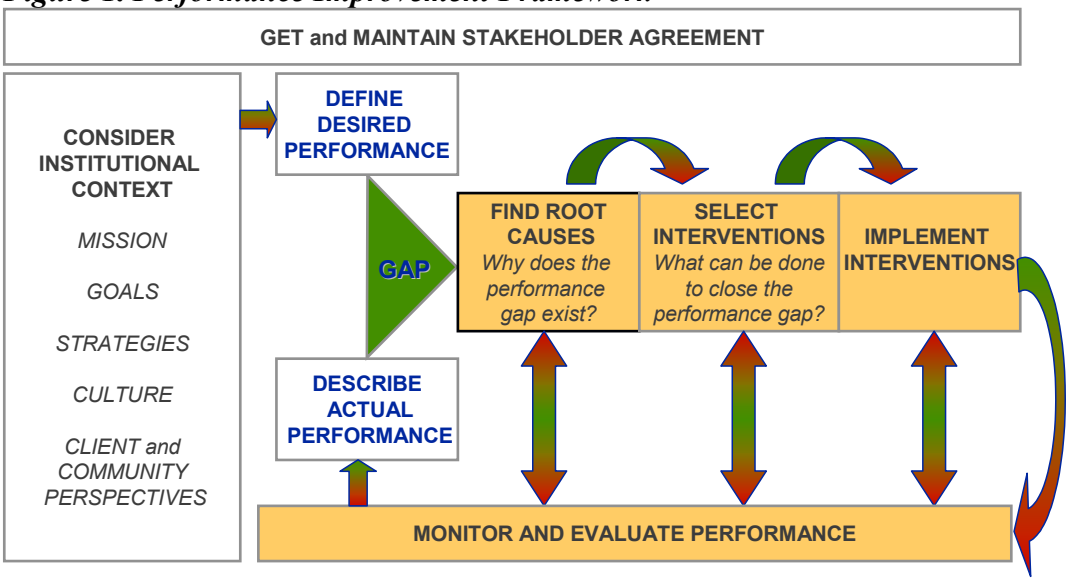
The project ran from April 2001 through July 2002.

The focus of this project for STARH was to impart skills in undertaking a quality improvement process and to see how well clinics and their supervisors could proceed through all the steps. Given the small scale of 5 clinics, it was less important for STARH to critically and objectively measure changes in quality, thus the evaluation design was not as rigorous as it might have been.

Project Methodology

JHPIEGO's framework for performance improvement provided the organizing principle for this project. Below is the graphical representation of the framework. This helped us determine a logical sequence of activities, beginning with an assessment, as well as a tool for a performance improvement workshop, to aid in guiding quality improvement.

Figure 1. Performance Improvement Framework



Consistent with the JHPIEGO performance improvement strategy, each box of the framework involves a step or an activity. For example, the institutional context was important in this project, as it helped identify the clinics' desired performance. IBI was asked to share documentation of guidelines, both clinical and for the management of clinics, so that the institutional context could be taken into account in the process. This was very useful also for facilitators from STARH to provide context to the entire process.

Indeed, guidelines for clinic management already existed, as IBI had developed these with support from USAID's Service Delivery Expansion Support (SDES) project, which also provided funding to selected clinics for basic renovations, equipment and supplies and training of staff. According to IBI clinic management guidelines, the clinics were established to provide the following basic functions:

- To model midwifery services particularly in the area of IEC and IBI's devotion to the community
- To offer training and guidance, particularly for village midwives (*Bidan di desa)* who might use them for apprenticeships *(magang)*
- To serve as an information center (with references, BIDAN magazines, etc.) and a forum for meetings of IBI members
- To function as a referral center for clients of village midwives with difficult births or for family planning methods which the BDD are not yet competent to provide (e.g. IUD, implants)
- To serve as the secretariat for the local branch of the IBI Board (province or district)
- To support other activities (such as *arisan* groups, cooperation to procure medical supplies and drugs, etc.)

IBI also had guidelines for how to deliver clinical services. Translating these IBI references into measurable standards was one of the tasks of the performance improvement workshop.

Overview of Activities

A sequence of activities, involving supervisors, clinic managers and staff were implemented from May 2001 to July 2002. These are summarized in the following table:

Table 1. Summary of activities, participants and timeline

Activity	*Participants*	*Dates*
Meeting of supervisors to prepare initial clinic performance and quality assessment	From each clinic: • IBI Foundation supervisors • Head of IBI provincial board • IBI Clinic manager	May 2001
Initial clinic performance assessment	Supervisors and managers of clinics, coached by Central level board members	June-July 2001
Performance and Quality Improvement workshop to analyze gaps between desired and actual performance and plan interventions	• Supervisors • Clinic managers • Clinic staff (1)	October 2001
Follow up visits to each clinic and monitor progress on plan of action	Central board members visited clinics	January-February 2002
Repeat clinic performance assessment	Supervisors and managers of clinics, coached by Central level board members & STARH staff	June 2002
Results review and Lessons Learned meeting	3 individuals selected by each province	30 July 2002

Six central IBI board members participated in all the activities and regularly met with STARH staff to plan and monitor progress. At the first meeting, they were each identified with one clinic which they would supervise throughout the project (except for one board member, also employed at the Department of Health who did not have the time to travel). STARH staff occasionally accompanied IBI central board members on clinic visits. The last visit included at least one and sometime more than one STARH staff member.

For the initial assessment, STARH and IBI staff developed 10 different instruments to assess various aspects of quality, some of which were adapted from existing IBI tools used in SDES, some from training checklists and some were developed rapidly for the purpose of this assessment. The tools were:

- No. 1. Counseling Checklist
- No. 2 and 3. Infection Prevention Assessment Tool and Checklist
- No. 4. Partograph Completion Review Form
- No. 5. Support during Labor Checklist
- No. 6. Clinic Infrastructure and Competing Health Delivery Sites Analysis Form

- No. 7a. Client Interview Guide (Inside Clinic)
- No. 7b. Client Interview Guide (Outside Clinic)
- No. 8. Contraceptive Supplies Inventory, Pricing and Supply Data
- No. 9. Inventory of Equipment and Supplies
- No. 10. IBI Clinic General Information Form

The central IBI team then sent the tools to each province for use in self assessment. They also planned a visit to each clinic, sometimes accompanied by STARH staff, to either verify the results of the self-assessment or to participate directly in the assessment. In some cases, they needed to re-explain the assessment process and give instructions for the assessment to be completed after their departure.

Copies of the completed tools were sent to IBI in Jakarta and shared with STARH staff, who reviewed the results together in preparation for the workshop.

The 5-day October 2001 workshop was designed to introduce participants to the performance improvement process, to look at actual performance (reflected in the completed assessment tools) as compared with desired performance, to analyze key performance gaps and to make a plan to fill those gaps. The first day of the workshop was attended only by supervisors and clinic managers and was devoted to defining the role of supervisors, drawing organizational diagrams by province and imparting key supervisory skills. Selected chapters of an earlier draft of JHPIEGO's reference manual, *Supervising Health Services: Improving the Performance of People,* were translated and shared with participants as background reading for performance improvement. At the completion of the workshop, each clinic had developed an action plan, and supervisors had documented their personal commitment to the tasks of supervision by writing letters, which were mailed back to them after three months. Table 2 summarizes the gaps each of the clinics selected as the focus of their workplan.

Table 2. Performance Gaps Identified by Clinics

Clinic	***Gaps***
Bandung	• There is no full time midwife and services are not available 24 hours/day • Client privacy is not ensured
Deli Serdang	• Staff are young, part-time, turn over frequently, and are often absent • Services in counseling, prenatal care, intrapartum care and postpartum care are of inadequate quality • Caseload is low
Jakarta	Caseload should be 50% higher for all types of services
Lampung	Counseling is not performed using the "satu tuju" method*
Surabaya	The community is not well informed about clinic services; they believe erroneously that prices are high

* "Satu tuju" is the Indonesian adaptation of GATHER.

In the early months after the workshop, central level supervisors regularly called the clinics to ask for progress reports. At the first follow up visits, most clinics had initiated activities listed in their action plans, but it was clear they needed more time both to complete their workplans and to see the impact of the changes they had made.

For the repeat performance assessment, only four tools were used, based on a discussion between STARH and IBI managers:

- Infection Prevention
- Counseling
- Partograph
- IBI Clinic General Information Form (to see if they added staff, new kinds of services and changes in caseload)
- Support during Labor Checklist

The tools were selected because they measured the areas most commonly included in the clinics' workplans. Contraceptive supplies, for example, was not found to be a problem in any of the clinics, given that clinics could generally fill orders for additional stock from private distributors within no more than a day or two. Also, some of the assessment forms dealt with environmental variables, such as competing service delivery points, which would not have expected to change significantly over time, but had provided useful data in the root cause analysis.

Many of the results described below were identified through a review of repeat assessment tools, discussions with the teams, and from reports that clinic staff prepared ahead of the final follow up visits.

Results

Workplans were for the most part completed. In some clinics, workplan activities were either dropped, or, more commonly, added. Table 3 below shows clinic by clinic activities planned and completed, while also presenting the context for each clinic.

Table 3. Clinic by Clinic Review of Activities

Clinic	General Facts	Gaps in Quality/ Problems at the Start	Activities Planned	Activities Completed
Bandung, West Java	Fairly new clinic, 2 beds. Many of the midwives also trainers. Location on residential street, in suburb of the city. Low to middle class community.	Lead part time midwife also has private practice not far from clinic, prices set too high, not competitive with private midwives. 5 PT midwives. Caseload low: FP, mostly COCs and injectables. ANC 15/mo. Only 1 delivery, 3 home visits, 7 sick child	• Recruit a full time midwife • Ensure that counseling is provided according to *satu tuju* standards • Create a counseling room	• Recruited a full time midwife and put in place a schedule of PT midwives to provide 24 hour coverage • Created a counseling room • Created leaflets on clinic services • Instituted home visits for women in the 3rd day postpartum • Established a peer review system to improve infection prevention, counseling, use of the partograph, counseling and the 60 steps of basic delivery care • Held health seminars, using a book on MCH to educate women on health issues, created educational brochures as visual aids • Developed a client feedback survey with 3 questions
Deli Serdang, North Sumatra	Clinic with 4 beds. Location inside a housing complex for civil servants. Sprawling suburban town outside city of Medan.	Attempted to draw clients from areas outside housing complex, but distance was a problem. Because civil servants have Askes insurance, it was felt they would not use services. Midwife had recently left to continue her education, leaving only 1 PT midwife Infection prevention weak, particularly decontamination, waste disposal. Caseload dismal. But average of 20 home visits	• Provide guidance and coaching to staff • Create a reference collection • Find opportunities for staff to follow training • Increase provider salaries	• Recruited new staff (1 experienced midwife and 2 nurses to add to existing PT midwife) • Created a small collection of references on reproductive health • Started socializing clinic services to residents in housing complex where clinic is located • Created a gym class for pregnant women • Created a new baby-sitting service • Changed compensation package from salary to fee-for service/profit sharing so that providers's pay is directly related to caseload

Clinic	General Facts	Gaps in Quality/ Problems at the Start	Activities Planned	Activities Completed
Bandar Lampung, Lampung	Clinic with 7 beds, Ob Gyn available by appt. Busy residential area, lower middle class. Across from *Lurah*'s office (neighborhood chief)	Weaknesses in counseling. Weaknesses in infection prevention (HLD, cleanliness) Caseload higher than most: 90 COC & inj./mo, 14 LTM/mo, ANC 50/mo, 6 deliveries, 20 home visits, 30 well child and 40 sick child.	• Community outreach through *kader* (community volunteers) • Increase staff incentives • Train providers • Create a special room for counseling	• Held regular meetings with *kaders* and provision of incentives for referrals (free services, transport costs) • Standardized home visits to all women who delivered at the clinic • Revised upwards the price list for the services • Established new relationship with midwifery school, placement of students at the clinic and students working with *kaders* to visit pregnant women and provide ANC services • Increased staff salary & incentives • Provided on the job training and guidance to providers, particularly in counseling • Created a special room for counseling, renovated bathrooms, added sink and created instrument processing area, as well as VIP maternity room with private bath
Jakarta, DKI	Clinic downstairs, 10 beds, IBI offices upstairs. Location in downtown Jakarta, middle class neighborhood; residential street parallel to through street with government offices.	Low staff morale because of management practices. Clinic often deserted. IBI board member driver sleeping in waiting room FP Caseload low: mostly COC & inj. & condom. ANC 60/mo, 10 deliveries, 10 well baby. Fitness class, nutrition talk/demo	• Marketing of the clinic to the community (leaflets, *posyandu*) • Deliver counseling according to "satu tuju" standards • Create a counseling room and furbish it with visual aids	• Held meetings with 4 neighborhood groups • Held *Posyandu* (health fairs) in 4 neighborhoods • Held *Bakti Sosial* for IBI anniversary with free services • Created home visit schedule • Initiated baby-sitting services for children of midwives twice a week • Held meetings with *puskesmas*, neighborhood chiefs, etc. • Developed a leaflet about the clinic • Instituted universal counseling for all clients • Developed counseling skills through use of job aids (checklists) and coaching • Transformed office into counseling room • Posted signs throughout clinic to direct clients • Created job descriptions and schedule for tasks • Management of revenues transferred from foundation office to clinic manager • Service statistics graphics posted • Routine meetings, case reviews with PT obgyn • Recruited a PT general practitioner and a new midwife • Staff salaries increased • Incentives (e.g. for deliveries) increased • Purchased a washing machine and an ultrasound machine • Planning for physician services 24 hour/day

Clinic	General Facts	Gaps in Quality/ Problems at the Start	Activities Planned	Activities Completed
Surabaya, East Java	Clinic with 7 beds. Location on middle class residential street, near a busy lower class area with factory workers. Street gated at night.	Assessment step emphasized interviewing community members: discovery that many did not know the clinic existed or thought it was more expensive because of its location. Weaknesses in counseling Problems of many lacerations noted on partographs. Only 2 part time midwives. Caseload middling.	• Develop and distribute leaflets for community members (which include service prices) • Meet with community leaders to describe clinic services and prices	• Met with *kader*, village and subdistrict heads and other community leaders • Met with staff of public health facilities, encouraging them to send referrals • Initiated home visits, principally for maternal and child health services • Created a new sign for the road entrance near the clinic and arranged for the gate guard to facilitate passage of women in labor at night. • Developed a leaflet as well as a booklet on MCH for clients • Recruited another midwife, changed clinic manager (but existing midwife now going to school 3 days/week and lost a midwifery assistant) • Developed job descriptions/ more balanced workloads • Invited an ob-gyn to hold office hours twice a week at the clinic • Provided on the job training, guidance and feedback to staff to perform according to standards • Sent [1] staff to training in basic delivery services (*Asuan Persalinan Normal*) • Installed air conditioning in inpatient rooms as well as in the delivery room

Staff Knowledge and Skills

In general, the local supervisors increased how much time they spent at the clinic and provided on-the-job training and "peer review" to staff in areas where weaknesses had been identified. Counseling and improved interpersonal communication with clients were usually the focus of such training, with some noticeable improvements. Surabaya effectively used the assessment checklists to identify gaps (for example, counselor does not use audio visual aids or check whether client understood) and to focus efforts in these areas. While opportunities for more formalized training were rare, staff midwives from Surabaya and Bandung did receive training in basic delivery care.

IBI and STARH staff who visited the clinics repeatedly report that cleanliness also generally increased in all clinics and, in provinces where midwives had some training in infection prevention, such as West and East Java, infection prevention more generally improved.

Clinic Management

In some clinics, increased supervision and attention to the clinic led to changes in staffing, management (such as assigning and scheduling tasks) and allocation of resources. In a couple of clinics, the manner in which clinic revenues were handled was drastically changed. In Jakarta, the responsibility shifted from Foundation administrators who did not work at the clinic to the clinic staff themselves. Also in the area of financial management, the Deli Serdang clinic, where caseload is very low, changed its staff compensation structure from salary to a fee-for service system.

Four clinics (Bandung, Jakarta, Lampung and Surabaya) also invested in clinic infrastructure or reorganized existing rooms so as to create private counseling rooms. Jakarta put up signs and other client information aids to orient them around the clinic. In Surabaya, staff and supervisors ascribe the increase in delivery cases to the fact that family members, particularly husbands, are now welcomed into the labor room.

Two clinics (Lampung and Bandung) improved 24-hour coverage by ensuring that midwives stay physically onsite at night. This usually required the recruitment of additional midwifery staff. Being open in the evenings contributed not only to better obstetric services, but also benefited family planning. In Lampung, staff observed that clients prefer to come in the evening after work for FP services.

In addition, two clinics have recruited physicians on a part-time basis so as to expand the range of clinic services. Surabaya found an ob-gyn physician to practice twice a week in the IBI clinic (and ensured that prices for consultations were within reach of the community). Jakarta recruited a general practitioner working in a government office to provide services in the evenings (in addition to the part time obgyn already working with IBI).

The Surabaya clinic also worked early in the process at defining the vision ("Services and training site for high quality primary reproductive health care in support of Healthy Indonesia

2010") and mission ("Providing professional client-focused services by professional staff, so as to achieve optimal community health") of the clinic.

Client Focus

In most clinics, the performance improvement process successfully encouraged staff to focus efforts on improving client satisfaction. Lampung, Surabaya, Bandung and Jakarta worked on improving counseling in general, but also the general friendliness and welcome of staff. An example of the new climate was observed during one follow up visit in one of these clinics. The team from Jakarta was meeting with clinic staff in the waiting room in the evening, when a client timidly stood in the entrance of the clinic. One of the midwives jumped up as soon as she noticed her and took her into the family planning consultation room to serve her. She only rejoined the meeting after the client had left. In Bandung, the staff also developed a simple client feedback questionnaire and administered it with 44 clients.

The Deli Serdang clinic had ongoing difficulties in identifying its target clientele. Because of their location inside a housing complex, they are not very accessible by the low income population immediately outside the complex, and yet they originally targeted the low income community. They assumed that complex residents, being mostly civil servants, would not use the clinic, because their government insurance allows them access to more expensive providers. The clinic decided to add babysitting and fitness classes as additional services which might attract housing complex clients. As they did so, and expanded their marketing, they learned that some clients might forego outside services for the benefit of having a clinic so near, if the quality met their expectation. Belatedly, they have refocused their energy to the community right around the clinic, although the impact of these efforts has yet to be seen in their statistics.

Clinic Outreach and Marketing

Clinic outreach increased in recent months. For example, clinics were much more conscientious about initiating *posyandu* activities[1]. Similarly, the Bandung clinic collaborated with BKKBN to give free FP services on National Family Day and Jakarta also held a "Bakti Sosial" (special event) during the IBI anniversary where various services were offered. Also, home visits increased or were added (Lampung, Bandung, Jakarta), either to women having recently delivered with them (all clinics) or when *kader* identified pregnant women who had not yet been seen antenatally (Lampung) or upon calls from parents of a sick child (Jakarta).

Increased marketing of services to the community was a common improvement. Most clinics held some formal meetings with neighborhood and/or subdistrict chiefs. Some also worked with existing *kader* or community-based volunteers to increase referrals, assist during *posyandu* or health fairs. In Bandung, the IBI chapter and clinic staff worked together to develop health education brochures for clients (sample topics included birth preparedness, breast care during pregnancy, child immunization, newborn care, FP methods, etc.). In addition, leaflets with information about the clinic were printed and distributed (by all clinics except Lampung), most

[1] A *posyandu* is a type of health fair where free services are provided. Typically, a *posyandu* includes 4 or 5 stations to provide various services, such as family planning, antenatal care, immunizations, weighing and well baby care, etc.

often to clients coming to the visit and during *posyandu*, but also at other events. In Jakarta, clinic staff make a point of attending community events, such as weddings or circumcisions and making small offerings. The Bandung staff will visit *kaders* at home when they are sick.

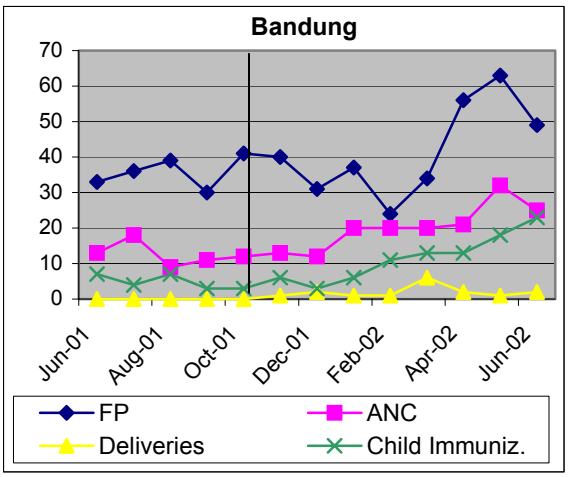
Partnerships

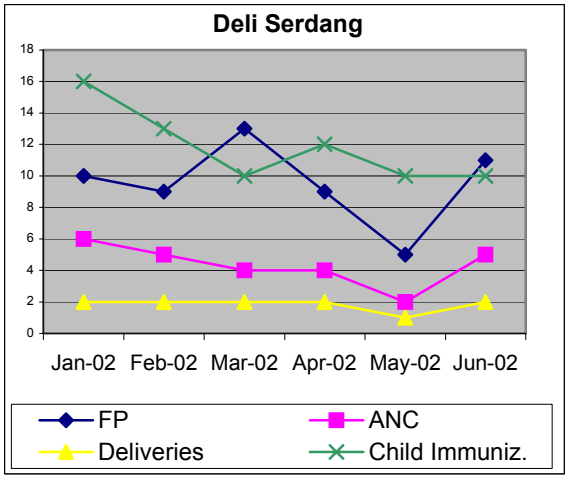
Many clinics (Surabaya, Lampung, Jakarta) approached other facilities to create increased opportunities for referrals. These partnerships resulted in cooperation whereby a private midwife or health center with more than one woman in labor might either send extra clients to the IBI clinic or ask for a clinic midwife to come and help for a fee. The Lampung clinic also created a partnership with the midwifery school, so that students could practice at the clinics, accompany *kader* on home visits and help market the services at the clinic. When students perform prenatal exams, the visit is free for the patient.

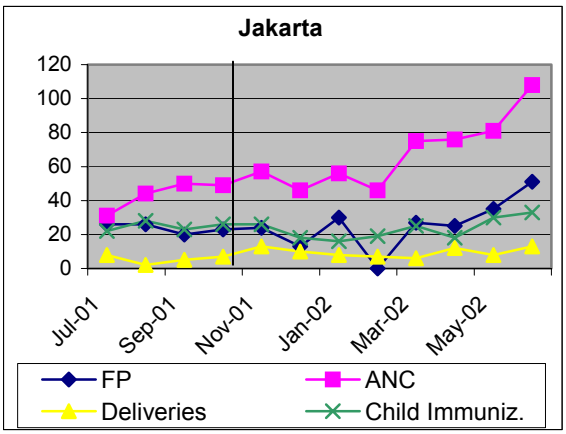
Increases in Caseload

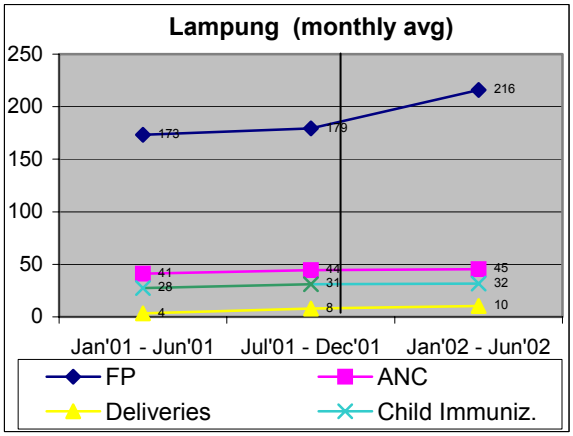
STARH staff asked for regular reports of service statistics as a proxy indicator of clinic performance, increased client focus and community perception of quality.

The following 5 charts show monthly service statistics in the period before the interventions as well as after. While the intervention started with an assessment in June or July, real work did not begin until after the performance improvement workshop in November 2001 (marked by a line in each chart). The Bandung, Jakarta and Surabaya charts indicate increases in caseload starting in March or April, suggesting that the clinics needed several months to put in place changes in clinic management, institute marketing activities or improve quality noticeably. Note that only 6 months of data was available for Deli Serdang and that Lampung presented its data over 6 month periods, so that the chart uses averages for those periods as opposed to actual numbers. The charts are listed in alphabetical order.

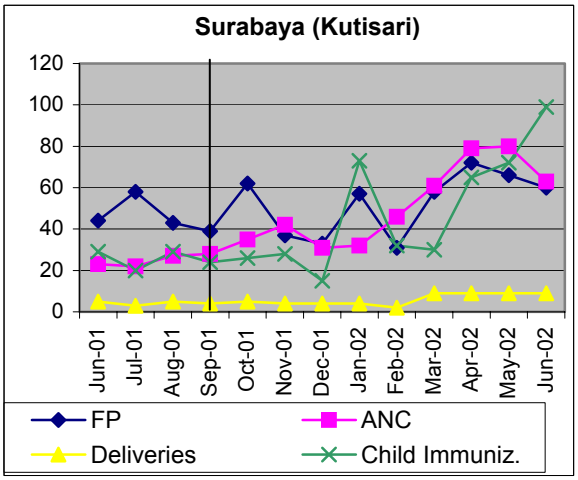






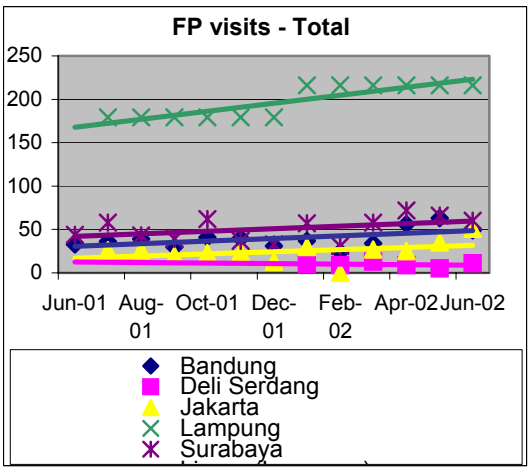


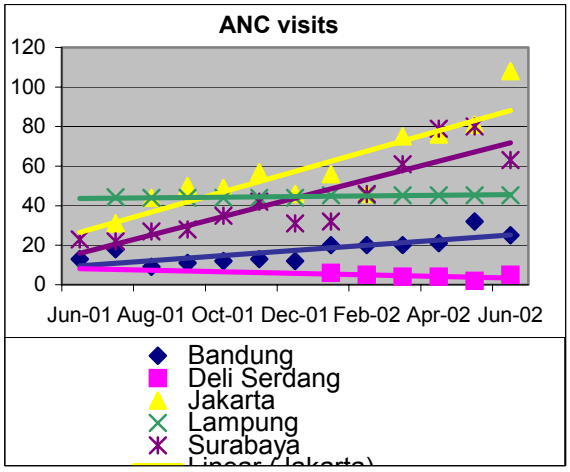
Note: Lampung reported data in totals for 6-month periods. Monthly averages were calculated here so as to allow volume comparison with the other clinics.



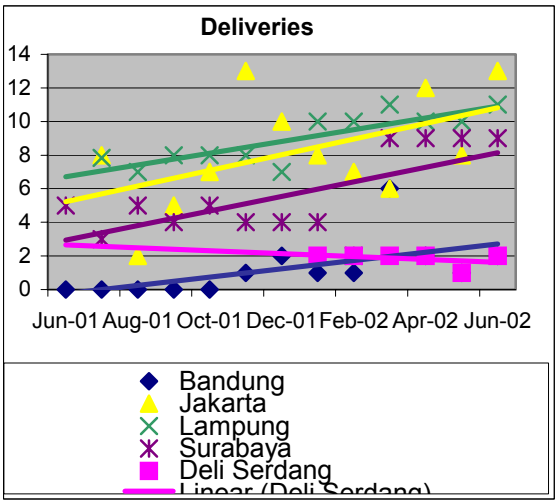
As shown, Lampung began with significantly higher caseloads than the other clinics, particularly for family planning. It is also interesting to see the variations in demand for services: Bandung and Lampung have a majority of family planning clients, whereas Jakarta offers more antenatal care services. Presumably, clinics have reputations for specific services. Perhaps, clinics could use benchmarking to reach better and faster results, for example if they focused quality improvement activities in those clinical areas where they presently have fewer clients in comparison with other similar clinics. Deli Serdang underperformed, both in overall numbers and in terms of increases over time. However, their staffing and management problems were not addressed until the month before the last follow up visit. Hopefully, improvements were still forthcoming after the last assessment.

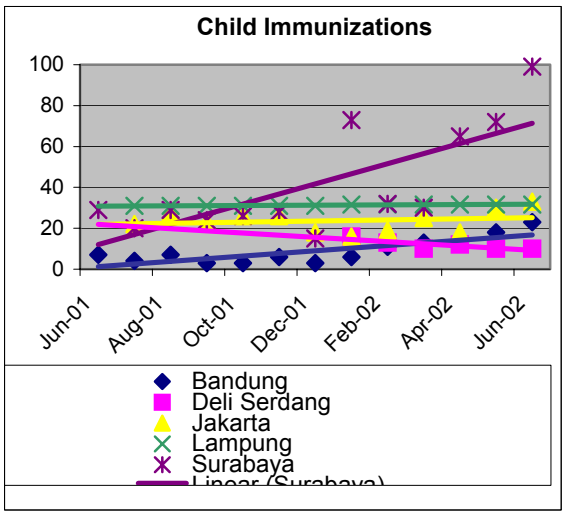
Another way to show the data is by comparing clinic performance within a service delivery component. The family planning chart seems to show less impressive increases than other services, but this is because Lampung's caseload is an outlier to the other clinics. Indeed, if the Lampung data is removed from the chart, the other three clinics – aside from Deli Serdang – showed the expected upward slopes. The increases in deliveries are the most consistent and bode well as a measure of increased client confidence and satisfaction with client provider interaction.





Note: Lampung data was aggregated over six-month periods. For the purposes of these charts, values are monthly averages.





Note: See above regarding Lampung data

While the caseload increases are not spectacular, they do reflect improvements in client satisfaction and/or greater efforts to market the services.

Limitations

The assessment process was not very rigorous in that self or peer assessment were used. Undoubtedly, self and peer assessment have limitations in obtaining unbiased accurate information. The focus of this project was to impart skills in undertaking a quality improvement process and thus the evaluation design was not as rigorous as it might have been. STARH attempted to transfer some concepts concerning assessment during both the preparation meeting and the workshop, but did not focus a lot of effort on applying these concepts in the clinics, as one of STARH's objective was to learn how clinic teams would apply the performance improvement process on their own. It was felt that the scale, 5 clinics, was to small to warrant additional resources for an objective evaluation of quality improvement. Indeed, the use of data

was perhaps not well understood or handled somewhat carelessly by the teams. Instead, the midwives seem to take particular interest in issues of motivation in the root cause analysis. They also quickly grasped the importance of client focus.

Analysis of Success Factors and Lessons Learned

At the closing meeting, clinic teams were asked to analyze the causes of their success. The predominant enabling factor varied from clinic to clinic:

- Internal motivation and incentives were the factors most often associated with success in Lampung. In Surabaya, incentives and motivational factors received equal weight with increased client focus as a reason for success in improving clinic performance.
- Organizational support and management were most commonly seen as enabling factors in the analyses of Bandung, Deli Serdang and Jakarta.
- Client focus appeared as a factor in improving performance in all 5 clinics, as did knowledge and skills of providers; however, client focus was seen as having a broader impact on quality than improving provider competence.
- Clear expectations appeared in two clinics, Jakarta and Surabaya.
- Unlike the other clinics, Surabaya's analysis included the greatest number of enabling factors, with none really standing out.
- Only Bandung mentioned supplies, although Lampung mentioned improvements in clinic appearance as keys to success.

Another finding from the analysis of success factors was that clinics derived a sense of pride and motivation from having been chosen to participate in the project and relished the attention from the central staff, provincial supervisors and STARH. Another clear finding was that clinics and supervisors were very aware of the financial implications of accomplishing the results they set out for themselves (in terms of either personal incentives, through profit sharing or salary increases, or increased revenues for the clinic/IBI as an organization). Better performance, in terms of caseload particularly, was definitively associated with increased funds. These funds were then applied to equipment, staff recruitment, clinic renovations, as well as increased staff benefits and income.

While many factors seem to play a role in driving improvement, incentives stand out. These take two predominant forms - participation in a project and increased income – each of which has different implications for sustainability and replication. It seems that some attention from central, even if ceremonial, may be needed in province-level replication of the model. It also suggests mechanisms, such as annual awards, which IBI or other organizations can use to help drive QI initiatives. As for increased income, it is unclear how much this incentive might work in programs that do not involve the private sector. Also, it might be interesting to see how this factor evolves over time. Does motivation fall again when the increase in income plateaus?

Recommendations from Various Stakeholders

During the final seminar in July, participants were divided into groups and asked to develop specific recommendations for both continuing to improve quality in the original 5 clinics and for expanding to new clinics. The presentations have been translated (loosely) below.

Representatives of the IBI foundation

Recommendations for foundation branches in other provinces and districts:

1. Form branches in all provinces and chapters where they do not yet exist.
2. Implement or strengthen activities which raise funds to support the sustainability of the organization.
3. Implement or improve cooperation with partners
4. Prioritize and encourage the establishment of maternity clinics in provinces or districts where they do not yet exist.
5. Guide or monitor existing clinics.
6. Periodically (annually or biannually) evaluate clinic activities.
7. Safeguard clinic providers and their livelihood and help ensure the welfare of IBI members.

Heads of Provincial Boards (Pengurus IBI)

1. Strengthen other clinics within each province following the model of clinics who have implemented the performance improvement process.
2. Develop guidelines for a clinic-based performance improvement process
3. Hold a workshop for the purpose of coming to agreement on implementing clinic-based performance improvement with the following participants: heads of IBI district chapters, Head of the Foundation, clinic managers.
4. Raise funds
5. Provide periodic technical guidance and supervision from the province.

Clinic Managers

1. Understand the tasks and authority of the clinic manager.
2. Improve the management of personnel by clearly allocating tasks and responsibilities.
3. Maintain communication and provide feedback to providers.
4. Be mindful of salary / welfare of employees and show care and appreciation in handling holiday and other leave and continuing education.
5. Appeal to staff to perform their work using the 5S - *Salam,sapa, senyum, sabar, sopan* (Shake hands, greet, smile, be patient and well mannered)
6. Increase employee knowledge and skills by providing guidance and training.
7. Clarify for providers the service standards, which must be followed (protocols).
8. Inform and socialize the existence of the clinic, using leaflets and discussions with community leaders.

Central IBI

A. Follow up with the 5 clinics
    1. Revise the clinic management guidelines
    2. Develop a module for clinic management
    3. Provide training in clinic management
    4. Provide periodic training in contraceptive technology

5. Continue to supervise and evaluate clinics
6. Provide rewards

B. Replicate clinic performance improvement model in 5 other provinces (Banten, Central Java, West Nusa Tenggara, West Kalimantan, West Sumatra).

C. Evaluate staff performance during routine meetings and provide guidance.

D. Increase and maintain supplies that exist.

E. Improve and sustain the reward systems.

F. Improve linkages and communication with organizations and communities (IBI central, puskesmas, private midwives, *posyandu*, volunteers, neighborhood and sub-district leaders) so as to continue to promote and socialize the clinics.

Conclusion

The project with IBI clinics offered STARH with useful information on quality improvement in Indonesia, albeit with private clinics only. This project has and will continue to inform STARH efforts on a wider scale. In addition, IBI has also expressed their appreciation for the assistance provided by STARH.

REFERENCES

IBI, 1997. **Panduan Pengelolaan Klinik Model IBI** [Management Guidelines for Model IBI clinics].

Appendix A. Performance Improvement Workshop Schedule

IBI PERFORMANCE AND QUALITY IMPROVEMENT WORKSHOP FOR CLINIC STAFF AND SUPERVISORS (5 Days, 10 Sessions)

DAY 1 (*Supervisors only*)	**DAY 2** *(all participants)*	**DAY 3**	**DAY 4**	**DAY 5**
A.M. (4 HOURS) **Opening**: Welcome and introductions Overview of the course (goals, objectives, schedule) Review course materials Identify participant expectations Precourse questionnaire Identify group and individual learning needs **Introduction to Supervision of Health Services (Chap. 1)** • What is supervision? • Supervisor responsibilities **Activity:** Clarifying role of Yayasan and Pengurus (central & provincial) toward IBI clinics	**A.M. (4 HOURS)** **Opening**: Welcome and introductions Overview of the course (goals, objectives, schedule) Review course materials Identify participant expectations **Performance & Quality Improvement Process** (Including performance factor exercise) **Activity:** Priority problem for each clinic using matrix handout **Defining Desired Performance for Your Clinic (Chapter 3)** • Creating a shared vision among your team members **Activity**: Creating a vision through pictures	**A.M. (4 HOURS)** Agenda and opening activity **Assessing Site Performance (Chapter 4)** • Self- and peer-assessments • Supervisor assessments • Patient feedback • Community perceptions • Using records and reports • Benchmarking **Activity:** Define quantitatively a baseline measure for the clinic using the assessment data **Finding Root Causes (Chap. 5)** • Finding causes of poor performance • What enables desired performance	**A.M. (4 HOURS)** Agenda and opening activity **Types of interventions (cont.)** • Motivational intervention: Performance feedback **Activity/Exercise**: Feedback role plays • Motivational intervention: recognition of achievements • Environmental interventions **Selecting and Implementing Interventions (Chap. 6)** • Selecting interventions **Activity:** Brainstorm and prioritize interventions • Mobilizing Resources • Managing Change	**A.M. (4 HOURS)** Agenda and opening activity **Activity:** Refine action plans. Specify the roles of each level of supervisor. **Monitoring and Evaluating Performance (Chap. 7)** ▪ Monitoring and evaluation ▪ Tools **Activity:** Discuss follow up by IBI Pusat and STARH
LUNCH	**LUNCH**	**LUNCH**	**LUNCH**	**LUNCH**
P.M. (3 HOURS) **Working With People (Chap 2)** • Communication skills **Activity:** Groups prepare role play for 4 types of communication skills **(If time) Teamwork (Chap. 2)** • Coordinating with stakeholders • Facilitating effective meetings **Instructions** for rest of workshop and homework letter Review of the day's activities	**P.M. (3 HOURS)** **Performance standards (Chapter 3, continued)** • Define and set performance standards **Activity**: Setting performance standards for the IBI clinics • FP services • Delivery services • Caseload • Logistics ☛ Role of each level (Pengurus/ Yayasan) Review of the day's activities	**P.M. (3 HOURS)** **Activity**: Creating a why-why diagram for gaps **Activity:** Prioritize root causes **Types of Interventions** ▪ Learning interventions: Staff development activities Review of the day's activities	**P.M. (3 HOURS)** **Activity:** Develop action plans Presentations and feedback from participants and facilitators Review of the day's activities	**P.M. (3 HOURS)** **Supervisor Activity**: Postcourse Questionnaire & collecting supervisor's letters **Workshop Summary** **Workshop Evaluation** **Closing Ceremony**
Assignment: Chapters 1B3	**Assignment**: Chapters 4, 6	**Assignment**: Chapter 6-7	**Assignment**: Revise action plans (Supervisors: finish letter)	

Appendix B. Individual Evaluation and Feedback Form

As part of the final project seminar in July 2002, STARH asked each participant to complete a written questionnaire, looking back at the various activities implemented throughout the year-long process. The questionnaire used a four-point Likert scale to rate the usefulness of activities in meeting the objectives of improved quality and increased caseloads. The questionnaire listed 6 activities for all respondents and 3 additional activities for supervisors only:

Items to rate using Likert scale in evaluation form

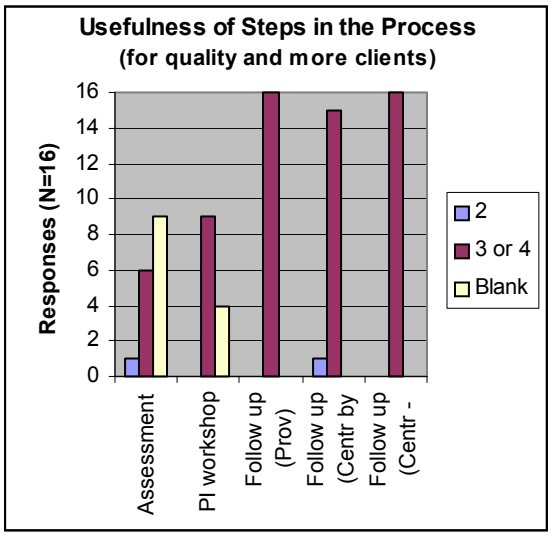
All respondents:

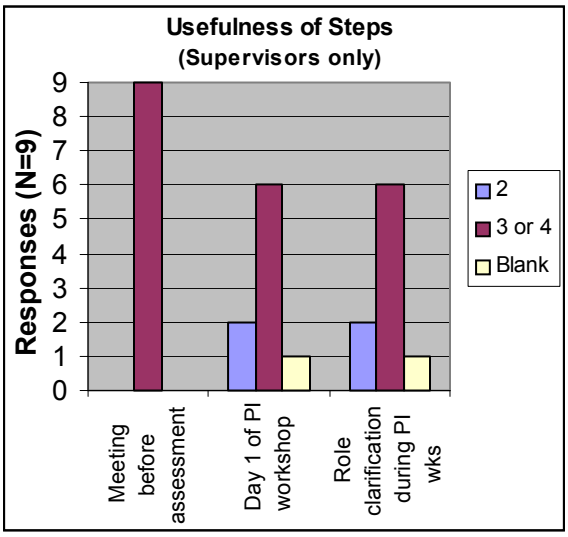
- Quality assessment using 10 instruments
- Performance Improvement workshop to analyze results and plan improvement interventions
- Follow up and support by supervisors, including:
  - Periodic visits by province-level supervisors
  - Follow up telephone calls by central supervisors
  - Visits by central supervisors

Supervisors only:

- Initial meeting of supervisors prior to assessment
- During the PI workshop:
  - Day 1 for supervisors only to define their role
  - Supervisor commitment document in letter to self

No respondent rated any item as 1 or least useful. In the graphs, ranks of 3 and 4 are grouped together. Several respondents skipped some of the questions. The results are shown graphically below.





It is interesting to note that supervisory activities were seen as most useful, even if done by telephone. Both clinic staff and the supervisors themselves concur on this point.

The participants were also asked for their feedback as to whether the assessment step should best be performed as a self assessment by clinic staff, by provincial supervisors or central-level supervisors. While the majority, 11 out of 16 respondents, selected self-assessment (not shown), two respondents chose a combination of self and external assessments. Province and central assessments each received 2 responses, a provincial supervisor suggested a combination of assessments by province and central, and 2 declined to answer. Many of the respondents noted that involving the clinic staff in the assessment process gave them a sense of ownership and motivated them to overcome gaps in quality.

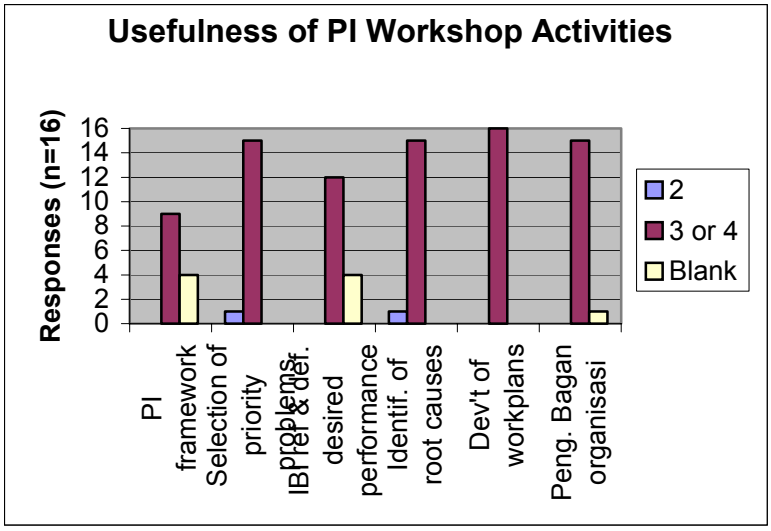
In addition to these overall steps, the questionnaire asked participants to rank the specific activities of the performance improvement workshop, using the same scale.

The questionnaire listed 6 activities for all respondents and 3 additional activities for supervisors only:

Specific Activities during Performance Improvement Workshop

- Use of PI framework
- Selection of priority problems
- Review of IBI references and definition of desired performance standards
- Gap analysis and identification of root causes
- Development of workplans
- Development of supervisory organigrams

The results are shown graphically below. Participants rated the development of workplans most highly, followed by selection of priority problems, analysis of root causes and supervisory organigrams. The performance improvement framework received the lowest usefulness ratings, suggesting that theoretical frameworks as perhaps not as valuable as some of the more practical steps.



In addition to quantitative measures, the questionnaire asked for recommendations in implementing each step and in general. Most of the recommendations deal with continuing to hold workshops and provide follow up and support to the clinics on a periodic basis and for replicating the process with other clinics. These recommendations tended to reiterate the results of the group discussions on recommendations described below.